Public Document Pack

Sefton Council

MEETING: HEALTH AND WELLBEING BOARD

DATE: 13th September 2023

TIME: 2.00 pm

VENUE: Committee Room - Bootle Town Hall, Trinity Road, Bootle, L20 7AE

Member

Cllr. Ian Moncur (Chair)
Cllr. Paul Cummins
Cllr. Mhairi Doyle, M.B.E.
Deborah Butcher
Margaret Jones
Sarah Alldis
Dr. Rob Caudwell
John Turner
Anne-Marie Stretch
Neil Holland
Janine Hyland
Andrew Booth
Superintendant Dawn McNally
Mark Thomas
Adrian Hughes
Angela White
Anita Marsland

COMMITTEE OFFICER: Amy Dyson Democratic Services Officer
Telephone: 0151 934 2045
E-mail: amy.dyson@sefton.gov.uk

If you have any special needs that may require arrangements to facilitate your attendance at this meeting, please contact the Committee Officer named above, who will endeavour to assist.

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A G E N D A

1. Apologies for Absence

2. Minutes of Previous Meeting (Pages 3 - 6)

Minutes of the meeting held on 7 June 2023

3. Declarations of Interest

Members are requested at a meeting where a disclosable pecuniary interest or personal interest arises, which is not already included in their Register of Members' Interests, to declare any interests that relate to an item on the agenda.

Where a Member discloses a Disclosable Pecuniary Interest, he/she must withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest, except where he/she is permitted to remain as a result of a grant of a dispensation.

Where a Member discloses a personal interest he/she must seek advice from the Monitoring Officer or staff member representing the Monitoring Officer to determine whether the Member should withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest or whether the Member can remain in the meeting or remain in the meeting and vote on the relevant decision.

4. Primary Care Update (Pages 7 - 24)

Presentation by NHS Cheshire and Merseyside, Sefton Place

5. Board Development (To Follow)

Report of the Executive Director of Adult Social Care and Health

6. Sub-Group Updates (Pages 25 - 98)

Report of the Director of Public Health

THIS SET OF MINUTES IS NOT SUBJECT TO "CALL IN"

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE COMMITTEE ROOM - BOOTLE TOWN HALL, TRINITY ROAD, BOOTLE, L20 7AE ON WEDNESDAY 7TH JUNE, 2023

PRESENT: Councillor Moncur (in the Chair) (Sefton Council) Councillor Cummins (Sefton Council), Deborah Butcher (Sefton Council), Margaret Jones (Sefton Council), Dr. Rob Caudwell (NHS Cheshire and Merseyside Integrated Care Board), John Turner (Healthwatch, Sefton), Neil Holland (Liverpool University Hospitals NHS Foundation Trust), Angela White (Sefton Council for Voluntary Services) and Anita Marsland (Sefton Partnership Governance)

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Doyle (Sefton Council), Sarah Alldis (Sefton Council), Andrew Booth (Sefton Advocacy), Adrian Hughes (Alder Hey Children's NHS Foundation Trust), Janine Hyland (Parenting 2000), Superintendent Dawn McNally (Merseyside Police) and Mark Thomas (Merseyside Fire and Rescue).

2. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 8 March 2023 be confirmed as the correct record.

3. DECLARATIONS OF INTEREST

No declarations of any disclosable pecuniary interests or personal interests were received.

4. SUB-COMMITTEE UPDATES

The Board considered the report of the Director of Public Health that provided an update and summary of activity from the identified sub-groups. The last update was heard on the 7th of December 2022.

(1) Children and Young People's Partnership Board (CYPPB) had met twice since the last report, on 15 February 2023 and 19 April 2023. The Board received updates regarding Communications, Governance, Early Help, Performance Data, Risk, Education, an upcoming SEND Inspection and the Improvement Plan.

(2) Sefton Adults Forum which had met twice since the last report, on 28 March 2023 and 23 May 2023. The Board received updates on the Place Plan, Care Homes and Domiciliary Care, Communications, Early Help and Prevention.

(3) The Health and Wellbeing Executive had not held any formal meetings since the last report but had prepared the Better Care Fund 2022-23 for approval from the Health and Wellbeing Board.

(4) Health Protection Forum which had met once since the last update, in May 2023 and discussed the uptake of routine childhood immunisations across Sefton. A number of Health and council bodies are working together to improve uptake. A rise in nationwide measles cases was also discussed.

The Board also received an update from the Combatting Drugs Partnership who had met once since the last report, on 20 May 2023.

RESOLVED: That

(1) the updates from the identified subgroups and Combatting Drugs Partnership be noted;

(2) the Better Care Fund 2022-23 be approved.

5. SEFTON PLAN 2023-25

The Board considered the report of the Executive Director of Adult Social Care and Health and NHS Place Director (Sefton). The Plan is a strategic document that sets out key objectives across the life-course with intended impacts and time frames and is a 'live' document that adapts to Sefton's ever-changing communities. The Board were informed that the Sefton Plan 2023-25 had been developed collaboratively through engagement. An easy read version and summary document of the Plan is in development.

The Board discussed funding for the plan and the importance of maintain a Sefton perspective.

A query was raised regarding the Summary of the report which stated that the plan would also support the delivery of:

• The Joint Health and Wellbeing Strategy, Living Well in Sefton
• The Cheshire and Merseyside Health and Care Partnership Strategy
• The NHS Cheshire and Merseyside Joint Forward Plan
• The NHS Operational Guidance for 2023/24

and whether this meant we were approving the Cheshire and Merseyside Health and Care partnership strategy, and it was confirmed that this wasn't the case.

RESOLVED: That

(1) the purpose of, and collaborative approach and engagement undertaken in developing the Sefton Plan be noted;

(2) the feedback and comments of the Board on how best to advance delivery in collaboration with partners and communities be noted;

(3) the approach of the plan being a 'live' document that can respond to the changing needs of Sefton's communities be endorsed;

(4) the Sefton Plan 2023-25 be approved.

6. INTEGRATED CARE BOARD JOINT FORWARD PLAN

The Board considered the joint report of the Executive Director of Adult Social Care and Health and NHS Place Director (Sefton) and the Head of Strategy, Assistant Chief Executive Directorate, Strategy and Collaboration Team (NHS Cheshire and Merseyside).

The report outlined a summary of the Integrated Care Board Joint Forward Plan which included priorities for Sefton and the delivery of the Joint Health and Wellbeing Strategy, Living Well. The Board were informed that the Plan must be published by the end of June 2023 and the final document will be submitted for approval to the Integrated Care Board on June 29th.

The Board discussed the challenges of governance that relate to the Plan.

RESOLVED: That

(1) the approach being taken in developing the Cheshire and Merseyside Joint Forward Plan be noted;

(2) a statement based on the feedback discussed at the meeting be drafted and circulated to the Board for confirmation by the Director of Adult Social Care and Health and NHS Place Director (Sefton) and the Assistant Director of Life Course Commissioning.

7. SPECIAL EDUCATIONAL NEEDS AND DISABILITIES JOINT COMMISSIONING PLAN

The Board considered the joint report of the Executive Director of Children's Social Care and Education and Executive Director of Adult Social Care and Health and Place Director (Sefton). The report outlined the development, key points and next steps of the Special Educational Needs and Disabilities Joint Commissioning Plan 2023 – 2026.

The Board praised the level of co-production and the impact of parent carers on the Plan.

RESOLVED:

That the adoption of the Strategy be endorsed.

8. CHILD DEATH OVERVIEW PANEL ANNUAL REPORT

The Board considered the report of the Child Death Overview Panel – Merseyside, Sefton Council is responsible for reviewing child deaths within Sefton. The report included Overview and Processes, Achievements, Priorities for Next Year, Recommendations and Data and Analysis.

The Board discussed the development of maternity pathways through the NHS and the reduction in rates of smoking in pregnancy.

RESOLVED:

That the contents of the report be noted.

9. SUPPORTING SEFTON'S PLACE PRIORITIES - SEFTON CVS

The Board considered the presentation of the Chief Executive of Sefton CVS which provided the Board with an update relating to how relating to how Sefton's Voluntary, Community and Faith (VCF) sector can contribute to the priorities and themes detailed in the emerging Sefton Place Plan. The presentation included the involvement of the VCF sector in developing the plan, the value the sector brings to local partnership working aimed at improving outcomes for local residents, a high-level outline of the VCF Social Impact Tool and a number of relevant case studies.

The Board offered praise and thanks for all the work Sefton CVS undertakes in Sefton.

RESOLVED:

That the update be noted.

Sefton Council

Report to:	Health and Wellbeing Board	**Date of Meeting**	13.09.23
Subject:	Primary Care (General Practice) Update		
Report of:	NHS Cheshire and Merseyside, Sefton Place	**Wards Affected:**	
This Report Contains Exempt / Confidential Information	No		
Contact Officer:	Jan Leonard & Tracy Jeffes		
Tel:			
Email:	Jan.leonard@cheshireandmerseyside.nhs.uk Tracy.jeffes@cheshireandmerseyside.nhs.uk		

Purpose / Summary of Report:

The HWBB is asked to receive a presentation regarding the current arrangements for general practice commissioning in Sefton, an update on the key work programme relating to access to general practice services and an brief overview of some of the key developments led by the Primary Care Networks in Sefton.

Recommendation(s)

That the Board receive the presentation.

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NHS
Cheshire and Merseyside

Primary Medical Care Services

Jan Leonard & Tracy Jeffes

Sefton Place

NHS
Cheshire and Merseyside

How is General Practice?

20-40% increase in contacts since pre pandemic, exacerbated by care backlogs

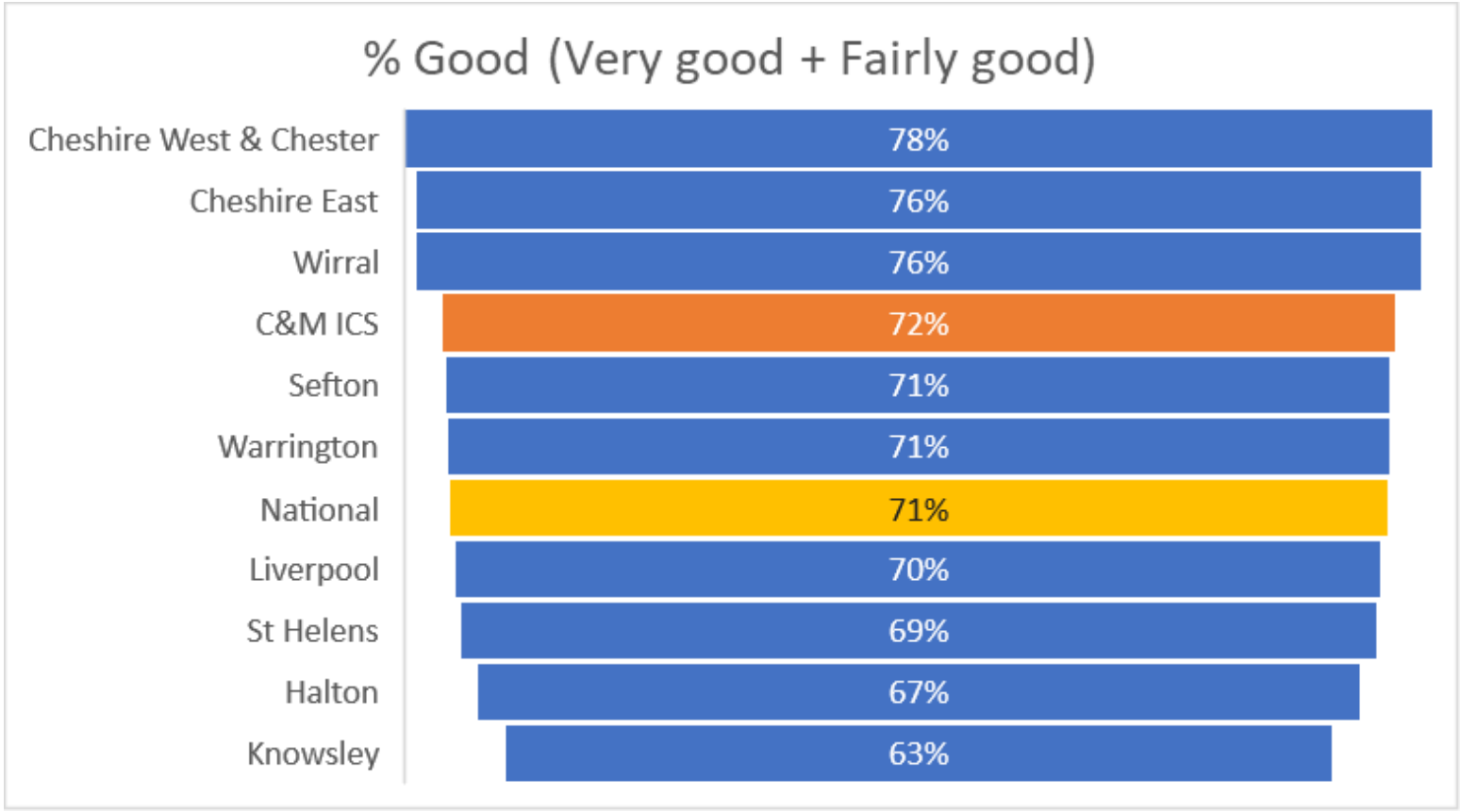
>30% increase in people >70 since 2010, with more **long-term conditions**

12% more appointments since pre-pandemic

Fewer fully qualified doctors working in general practice

GP Patient Survey 2023

NHS
Cheshire and Merseyside



The solution

NHS Cheshire and Merseyside

The Delivery Plan for Recovering Access for primary care was published in May 2023, with the aim of:

- tackling the 8am rush for appointments and reducing the number of people struggling to contact their practice;
- restoring patient satisfaction of accessing their general practice;
- and supporting a move to a digitally-enabled operating model in general practice.

Delivery Plan for Recovering Access to Primary Care

The plan headlines

The plan focuses on four areas to improve and recover access to primary care:

1	**Empower patients**	• Improving NHS App functionality	• Increasing self-referral pathways	• Expanding community pharmacy	
2	**Implement new Modern General Practice Access approach**	• Roll-out of digital telephony	• Easier digital access to help tackle 8am rush	• Care navigation and continuity	• Rapid assessment and response
3	**Build capacity**	• Growing multi-disciplinary teams	• Expand GP specialty training	• Retention and return of experienced GPs	• Priority of primary care in new housing developments
4	**Cut bureaucracy**	• Improving the primary-secondary care interface	• Building on the 'Bureaucracy Busting Concordat'	• Streamlining IIF indicators and freeing up resources	

Contracting for primary care

NHS Cheshire and Merseyside

Core contract type	Sefton
General Medical Services (GMS) contracts are nationally agreed with a payment of £102.28 per weighted patient in 23/24. GMS Contracts are awarded in perpetuity.	23
Personal Medical Services (PMS) are locally agreed contracts underpinned by national regulation. PMS contracts are awarded in perpetuity.	12
Alternative Providers of Medical Services (APMS) are provided under Directions of the Secretary of State for Health. APMS contracts can be used to commission services from traditional GP practices as well as others including (but not limited to) commercial providers or NHS Trusts. This contract is awarded on a time limited basis, typically 5 years.	5

Additional services

NHS
Cheshire and Merseyside

- Enhanced Services are nationally negotiated services, over and above those provided under usual contracts, which the area team/place is obliged to commission. A practice chooses whether to offer various services and get paid additional sums for this provision

- Out of Hours Care – funding top sliced from core contract. Covers outside of core hours and evenings and weekends

- Acute Visiting – home visits in hours after clinical triage

Quality & Outcomes Framework

Cheshire and Merseyside

The Quality and Outcomes Framework (QOF) is a voluntary scheme offered to all contracts. Changes to QOF are agreed as part of wider changes to the GMS contract which are negotiated by NHS England and the British Medical Association's (BMA) General Practitioners Committee (GPC) England.

The framework is broken down into Clinical, Public Health and Quality Improvement domains, with points awarded for achievement. Payment is based on achievement at year end.

Local Quality Contract (LQC)

NHS Cheshire and Merseyside

A 12 month contract commissioned by Sefton Place from general practice to deliver enhanced services over and above the core contract.

The intention is for the LQC to deliver schemes which result in quality improvements, efficiencies in the health economy, and sustainability of general practice.

Schemes (Phase 8)	Payment Structure
Part 1 Schemes for delivery by all practices, including access, prevention of disease, use of resources and prescribing quality	Equity based payment per weighted patient (includes core contract payment)
Part 2 Schemes that are optional to deliver including phlebotomy, shared care and drug administration	Activity based payments
Part 3 Schemes that are optional to deliver covering a broader population including ABPI, Vulnerable patients and Travellers	Activity based payments

Assurance and Contract Monitoring

Cheshire and Merseyside

Commissioners of primary medical care are responsible for the quality, safety and performance of services delivered by providers, within their area of responsibility.

This can be directly by NHS England (NHSE) local teams or ICBs through the delegation agreement.

Care Quality Commission

Cheshire and Merseyside

Care Quality Commission's role is quality compliance. Five areas of focus:

- Are services safe
- Are services effective
- Are services caring
- Are service well led
- Are services responsive to peoples needs

Primary Care Networks

NHS Cheshire and Merseyside

- PCNs are groups of GP practices who have agreed to work together, though a formal agreement to:
  - to support the development and sustainability of general practice services
  - work with other partners in their community to improve the health and wellbeing of local people.
- Whilst focusing on the needs of their local populations, PCNs have also agreed to deliver the requirements of a national PCN contract
- In Sefton we have two PCNs - Southport and Formby PCN and South Sefton PCN, who have the benefit of working at scale within the Sefton Partnership but also work in smaller neighbourhoods on the same footprint as with our integrated care teams to retain a local focus on the needs of different communities.

Primary Care Networks

NHS
Cheshire and Merseyside

Our PCNs offer a range of services through the additional roles scheme which include:-

- Enhanced Access services and the South Sefton Acute Respiratory / Access Hub service which both provide additional access to primary care across various locations

- The Enhanced Health at Home service - working with the Integrated Care Teams and wider community services to offer more proactive care to older people living in their own homes

- Enhanced Health in Care Homes teams (both clinical roles and care coordinators) working with Integrated care Teams / community services and care home providers to offer more proactive care to care home residents.

- An integrated mental health offer with MCFT through Mental Health Practitioner roles and working on the development of CYP Health & Wellbeing Coaches working with Alder Hey and VCF sector colleagues

Primary Care Networks – further examples

NHS Cheshire and Merseyside

- Care communities pilots – In South Sefton the ACEs (Adverse Childhood Experiences) programme is an integrated approach with Sefton Council and also closely connects with sexual health services. In Southport and Formby work is focusing on patients who experience complex lives to improve outcomes for this cohort via collaboration and partnership working.

- The social prescriber link worker service - a partnership with Sefton CVS who host the roles and work increasingly more closely with community and mental health services with referral routes in and out of Integrated Care Teams as well as GP surgeries.

- Clinical Pharmacy – PCN Pharmacists work in an integrated team within Sefton Place, supporting delivery of a range of services such as proactive medication reviews

- Administrative hubs – supporting general practices across Sefton through collaborative working on shared tasks.

- System partners – working across the Sefton Partnerships on a range of strategic developments such as estates opportunities.

Strategic Challenges

NHS
Cheshire and Merseyside

- Increasing demand

- Estates

Current practice estate has constraints

Opportunities for new developments with partners

Changing clinical model requires estates to support

- Workforce

Expansion of the multi disciplinary team

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	Wednesday 13 September 2023
Subject:	Sub-Group Updates		
Report of:	Director of Public Health	**Wards Affected:**	(All Wards)
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

This report is to present the Health and Wellbeing Board with a summary of activity from the five identified subgroups and seek approval for the Better Care Fund Planning Template 2023-25. The report also includes a summary of activity from the Combatting Drugs Partnership and outlines changes to pharmacies in Sefton. This is activity since the last report received by the Board on the 8th of March 2023.

Recommendation(s):

(1) The Updates from the five identified subgroups and the Combatting Drugs Partnership are received and noted by the Board;

(2) The Board approves the Better Care Fund Planning Template 2023 -25; and

(3) The Board notes the changes to Pharmacies in its area.

Reasons for the Recommendation(s):

The Board is asked to routinely receive and note updates to ensure compliance with required governance standards.

Alternative Options Considered and Rejected: (including any Risk Implications)

None

What will it cost and how will it be financed?

(A) Revenue Costs

The contents of this report do not incur additional revenue costs.

(B) Capital Costs
The contents of this report do not incur additional capital costs.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):

There are no resource implications.

Legal Implications:

There are no legal implications.

Equality Implications:

There are no equality implications.

Impact on Children and Young People: Yes

The Children and Young People's Partnership Board is one of the Sub-Groups included in the update report.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

Contribution to the Council's Core Purpose:

Protect the most vulnerable:

Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact. A number of the Sub-Groups are focused on helping the most vulnerable.

Facilitate confident and resilient communities:

Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact. A number of the Sub-Groups regularly work with communities.

Commission, broker and provide core services:

Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact. A number of the Sub-Groups are responsible for assisting with the provision of core services.

Place – leadership and influencer: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact. A number of the Sub-Groups are involved/included with(in) the Sefton Place Plan.
Drivers of change and reform: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact. A number of the Sub-Groups are responsible for facilitating change across Sefton.
Facilitate sustainable economic prosperity: Not Applicable
Greater income for social investment: Not applicable
Cleaner Greener: Not applicable

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.7362/23.) and the Chief Legal and Democratic Officer (LD.5562/23.) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Not applicable.

Implementation Date for the Decision

Immediately following the Board meeting.

Contact Officer:	Amy Dyson
Telephone Number:	0151 934 2045
Email Address:	amy.dyson@sefton.gov.uk

Appendices:

The following appendices are attached to this report:

1. Better Care Fund Narrative Plan Template
2. Sefton Better Care Fund 2023-25 Planning
3. SEND CIB Governance Proposal

Background Papers:

Agenda Item 6

There are no background papers available for inspection.

1. Introduction/Background

1.1 As agreed at the December 2019 meeting of the Health and Wellbeing Board, the Board receives a standard agenda item of summarised activity of its formal Sub-Groups.

1.2 The Sub-Groups are identified as:

- Children and Young People Partnership Board
- SEND Continuous Improvement Board
- Adults Forum
- Health and Wellbeing Board Executive
- Health Protection Forum

1.3 The Board also received regular Combatting Drugs Partnership updates which is included in the report.

1.4 Also included in the report is Sefton's Better Care Fund Planning Template 2023-25 for approval. This follows the approval of the Better Care Fund 2022-23 at the last meeting of the Board (7 June 2023).

1.5 The Board is required to receive and note changes to Pharmacies in its area from NHS England which are included in detail below.

2. Children and Young People Partnership Board

2.1 This update details the activity of a meeting held on the 14th of June 2023. The Group met and discussed Virtual Schools; the post 16 offer is seen as a strength following expansion of the team and greater monitoring and work with Career Connect. Following closer follow up and targeted work there is improvement with the leaving care picture. The cost-of-living impact is being felt in terms of decision making but support has been offered. Greater Governance around the Virtual Schools is needed through SAPH and SASH.

2.2 The Board noted an ongoing review of short breaks in the area of children with disabilities and received an update on delivering best value programme that could attract additional external funding. The Board received an oversight on the links between NEET and the Caring business charter, further work is needed on the full pathway and understanding what is driving the numbers. The Caring Business Charter has now seen more than 62 signatories with a huge breadth and in-depth conversations are taking place. A Practitioners Panel has been created to look into this in more detail as it is recognised the Charter requires greater dialogues across all areas, to date there has been 40 young people referred to the Charter, with 20 still engaged in the process.

2.3 The Board also noted standard items of Key Risk and received the notes of the Early Help Partnership, Start Well and the Emotional Health and Wellbeing Partnership.

3. Special Educational Needs and Disabilities Continuous Improvement Board (SENDCIB)

3.1 The Board has not met since the last update; it was due to meet on the 13th of July, but the meeting was cancelled.

3.2 The SEND CIB Governance Proposal (found at Appendix 3 of the report) was agreed by the Chair of the Board on the 11th of July 2023. The proposal included the following items for approval:

- Revised CIB Governance structure and delivery groups
- Pre and post CIB meeting schedule and function
- CIB and supporting groups Terms of Reference review
- Chairs and Senior Leader representation
- CIB Decision/Action log to replace minutes
- CIB Agenda
- Delivery Groups reporting approach
- Development of a SEND local area data dashboard

4. Adults Forum

4.1 The Adults Forum have not met since the last update (prior to the agenda publication date). The next meeting is scheduled for the 6th of September.

5. Health Protection Forum

5.1 The Sefton Health Protection Forum last met in July 2023 for a development session.

5.2 The session provided an opportunity to reflect on what has worked well and what elements of the forum need to be reviewed and/or improved. Membership, functions and purpose of the group, and frequency of meetings were reviewed. New terms of reference will be considered by the Forum ahead of the next meeting in October.

5.3 The below possible key priorities for the group were discussed and will be considered within a workplan for the forum at the next meeting:

- Acute Respiratory Infections
- Measles
- Immunisations (with a particular focus on childhood immunisations)
- Blood borne viruses
- Harm reduction and drug related deaths
- Emergency planning and preparedness
- Community Infection prevention and control
- Antimicrobial resistance
- Learning from incidents

6. Health and Wellbeing Executive

6.1 The Health and Wellbeing Executive last met on the 17th of August 2023.

6.2 The Executive received an update on performance and finance which reflected that capacity is being met at maximum and highlighted the need to review further ongoing work on improvements and changes to the pathway. The Executive were informed of upcoming deadlines regarding the Better Care Fund.

6.3 The Executive were updated on progress with the Sefton Place Plan, Sefton has followed a bespoke approach aligned with the Joint Forward Plan Development. Each Place is updating its Health and Wellbeing Board/Partnership in accordance with its governance structure. Work is progressing to identify metrics that will facilitate monitoring and to produce an accessible version of the plan with a draft document to be shared for comments by the end of August.

6.4 The Executive received a Governance update which included the establishment of a tripartite panel process, meeting review tool and recommendations around consolidation of meetings. This builds on previous work defining that the CYPB requires a clear vision, to be re-established as a Forum that reports to the Sefton Partnership.

7. Combatting Drugs Partnership

7.1 The Combating Drugs Partnership (CDP) is a multi-agency forum that is accountable for delivering the outcomes in the 10-year Drugs Plan within local areas. CDPs will provide a single setting for understanding and addressing shared challenges related to drug-related harm, based on the local context, and need.

7.2 The local Sefton CDP meets quarterly and has met once on 27/06/2023 since the last update. The next meeting is 28/09/23.

7.3 Each CDP meeting has a themed spotlight session, the focus for the June meeting was on Drug related deaths / Blood Borne Viruses. Discussions took place around individuals who are not engaged with Services and Sefton reaching national targets for increasing numbers into structured treatment. The Partnership have agreed Supplemental Substance Misuse Treatment and Recovery Grant (SSMTR) funding for Council for Voluntary Service (CVS) to undertake engagement work to gain insight into individuals and families impacted by drug and alcohol use, who do not engage with services.

7.4 Feedback was provided on the Mersey CDP with regional/national updates shared. It was agreed where it makes sense to work collaboratively as a sub-region of Cheshire and Merseyside on potential issues.

7.5 The draft Local Delivery Plan was presented; this was an opportunity for partners to review and provide feedback before sign off. Attendees stated they were happy with the final version. The plan will be reviewed on an annual basis with updates and actions shared with the partners.

7.6 A version of the local Sefton CDP dashboard was tabled and an update on progress provided. Gaps in data were discussed and requests made to partner

agencies to provide information were possible. It was noted that the national Outcomes Framework has now been released which will use data to be provided by National Drug Treatment Monitoring System (NDTMS), which local CDPs can also use for monitoring.

7.7 A draft version of the annual Stocktake was requested to be undertaken nationally by all CDPs was shared, partners were provided with an overview of the CDP and a summary of progress against national requirements. Sefton is on target for meeting all requirements for year 1.

7.8 In line with National guidance voice lived experience will need to play a role in influencing the work of the CDP, developing this role locally will be part of the work programme moving forward of the partnership.

7.9 Local issues concerning the use of Nitrous Oxide Gas in school settings was highlighted. It was agreed that Change, Grow, Live (CGL) would create an educational message which could be shared with schools. This would include information services for young people and guidance for parents.

7.10 Sefton CDP contributed to a report for the Merseyside CDP chaired by the PCC Office which is attended by the Sefton Senior Reporting Officer – Margaret Jones.

7.11 A CDP briefing is going to the Cabinet Member for Health & Wellbeing Meeting in September.

8. Pharmacy Updates

8.1 The Health and Wellbeing Board is required to receive and note changes to Pharmacies in its area from NHS England. From June 2023 to date, the following notifications have been received:

Pharmacy	Notifications
Aim RX Ltd Bridge Road Chemist 54-56 Bridge Road	Reduction in opening hours from 100 hours to 72
Asda Stores Limited Asda Pharmacy 81 Strand Road	Reduction in opening hours from 100 hours to 72
Sharief Healthcare Ltd L Rowland & Co (Retail) Ltd 15 Chapel Lane	Change of Ownership

9. Better Care Fund Planning Template 2023-25

9.1 Appendix 1 contains a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

9.2 Appendix 2 contains Sefton's Better Care Fund Planning Template 2023 -25 for approval by the Board.

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HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Sefton Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

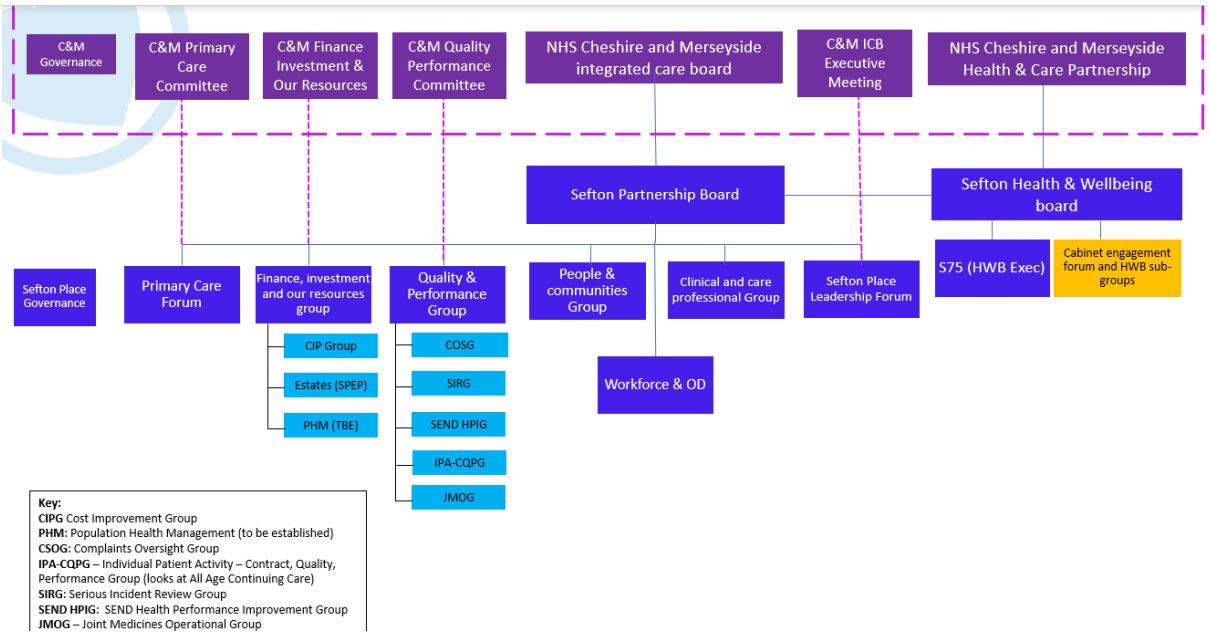
Strategic Housing Forum, Sefton CVS, NHS Acute providers and Community Providers, Health Watch, Sefton Council, ICB – Sefton Place.

How have you gone about involving these stakeholders?

Utilisation of the Sefton Partnership infrastructure, we have shared with the Partnership board for comment, and we have actively engaged with key stakeholders from this group through our BCF working group.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

The plan reflects our key priorities to support maximising independence at home wherever possible. It reflects a clear commitment to Intermediate care growth and working with the domiciliary care market differently to deliver. It also represents our ambition to grow alternatives such as adaptations, creative uses of the DFG programme and growth of the use of telecare and community equipment. We continue to see elements of key children's service delivery which has helped us drive integrated improvements in this area. A big development is the investment in 2-hour response, third sector support to discharge and widening of the discharge hub model. All these elements contribute to early intervention and prevention, and we believe the overall reduction in unplanned care and getting people home quicker when they do need hospital support.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our Partnership plan supports delivery of the borough's health and wellbeing strategy, Living Well in Sefton. We share a single vision, namely that Sefton will be:

"A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future".

Our plan sets out our objectives across the life-course, starting from pregnancy and continuing right through to supporting those who are nearing the end of their life. This underpins our shared commitment to adopting a "whole population, whole partnership" approach to delivery. In order to realise both our vision and shared commitment, we have identified three cross-cutting themes: reducing health inequalities, service transformation and community first.

Please see our appended place plan for more detail.

Key achievements to date of the partnership that use the BCF to help drive integration are:

With the support of our partners, we developed a new delivery model that provides an integrated frailty unit with intensive reablement at our Chase Heys service.

The service launched in January 2023 with an additional 14 beds and has already **achieved some impressive outcomes, supporting patients to return home more quickly and releasing hospital beds.**

Our new 2-hour Urgent Community Response (2hr UCR) service has been highly effective in reducing the need for our most vulnerable patients to be admitted to hospital.

We have seen referrals jump with performance rates averaging 80-90% against a 70% target. We continue to develop the service, to support more admission avoidance, as well as ensuring integration with wider developments.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Within the BCF plan, Sefton have an integrated health and social care intermediate care strategy. The strategy has four models of delivery; 2-hour urgent care response (UCR), reablement, home first and bed based intermediate care. The aim of intermediate care is to enable people to stay independent within their own homes for as long as possible.

The delivery of the 2-hour UCR has been commissioned collaboratively across a range of private, community, local authority, and voluntary sector services. Following the initial response there is a reablement period which requires services to work in an integrated way to ensure that the needs of the individual are met.

Examples of this work include, falls pick up services working with reablement and therapy services, Northwest Ambulance Services interfacing with community teams and the acute visiting service. We have invested in specialist service provision to ensure that teams are equipped to deal with complex clinical presentations such as exacerbation of respiratory illness or intravenous therapy for the treatment of skin and lung infections. This integrated team accepts referrals 12 hours per day, 7 days per week and outcomes show that we >70% of referrals are seen within 2hrs and that patients are being treated and remaining in their own homes.

In Sefton via the BCF, we have provided bespoke urgent care response for the open care home market which has demonstrated effective outcomes such as reducing demand on the ambulance service and reductions in hospital conveyances.

Pivotal to the delivery of our intermediate care strategy, is the integrated community reablement assessment service (ICRAS). This team consists of nurses, therapists, frailty specialists, primary care medical team, pharmacy, reablement, VCF health and well-being practitioners and unpaid carers. Together they deliver home first services, reablement services and in reach multidisciplinary and discharge services to the acute trust and community bed bases. Referrals are accepted from the community and the acute trust. The aim to assist the individual to remain at home following a period of illness or if they need

support to regain independence. This team can step up or step-down individuals into the community bedded facilities for a short period if required.

In some instances, individuals may require closer monitoring on discharge from hospital or have a greater risk of hospital readmission. This may be due to certain treatment regimes or a change in clinical condition and involves virtual clinical management of vital signs in collaboration with nursing and medical teams. The integrated services within the 2hr UCR or community MDT's will be able to refer into the virtual ward from primary, community or secondary care via the UCR, this also includes paramedics. All virtual wards will support Early Supportive Discharge from hospital, they include respiratory, heart failure and frailty at present and will include palliative care.

The BCF plan also includes support to our carer's advocacy service and the vital work of unpaid carers. Sefton Carers Centre provides free advice and guidance, emotional and practical support, training, and a range of holistic therapies for unpaid carers living in Sefton. The pooling of budget through the better care fund allows us to take an integrated approach to planning a long-term service that allows carers to keep on caring for loved ones. They also provide Sefton's one-off personal health budget service to support individuals and families to purchase essential items such as bedding or kitchen equipment to ensure that activities of daily living are maintained and reduce risk of ill health.

Our DFG process has seen significant improvements and we hope to continue to grow this in the coming 2 years. We have reduced bureaucracy through the development of the Adult Social Care online Portal, development of extended warranties and revised means testing now applied only for applications over £10k. This allocation also includes monies for increasing capacity to manage expected increase in demand for DFG's of around 3 posts. This is recognised as critical in keeping more people at home with a minimised need for more formal care and support.

The Better Care Fund supports our community equipment service and its continued growth this service is vital in providing personalised solutions to maintain independence for longer and we continue to expand our discharge offer, work in partnership to maintain the level of service, meaning urgent request can be fulfilled with 24-48 hours supporting and promoting effective discharge. The expansion serves both adults and children and improvements to the service offer such as increasing the digital ordering system reach and expanding the range of specialised equipment available. We also continue to progress to a single pathway for technology enabled care, equipment, and adaptations.

Through joint working, a no wrong door approach reduces hand offs, and our Integrated Care Teams ensure that holistic care is delivered. Close working with Primary Care Networks has seen the development of new roles to support our residents to self-care where possible and deliver focused care where necessary. The development of a medicines hub means that everyone discharged has their medications reviewed to maximise compliance and reduce the risk of readmission.

Improving same-day access for urgent care is key to reducing unwarranted hospital attendance and creating space in primary care to deliver more continuity of care. Some of the initiatives that have been implemented include direct booking from primary care to secondary care same day emergency centre (SDEC) services, primary care paramedic

clinics, access to NHS urgent medicine supply advanced service (NUMSAS) pharmacy provision. The development of primary care networks and the interface between the wider MDT is within our BCF plan. Delivery of services at neighbourhood level, intervening early and responding to the person in the context of the community is our system approach. Utilising community assets to support the individual with short- or long-term care goals to ensure that they remain as well as possible and as independent as possible.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations

    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The 23/24 capacity plan has been modelled on 22/23 demand. In 22/23, we were able to utilise the additional funding from the national discharge fund to commission the capacity required to support discharge and hospital avoidance. The recurrent funding is now included in the BCF, and we have been able to evaluate the previous year's activity and plan against this.

We have also been able to identify areas of unmet demand and profile this against 23/24 commissioning intentions. Approximately 25% of all reablement referrals were redirected to alternative providers due to lack of capacity. The additional investment within the BCF has been allocated to address the capacity shortfall within reablement services. We have also had to utilise short term bedded placements at times of pressure for patients waiting for packages of care. Health and Social Care have undertaken a competitive procurement process to develop a framework of domiciliary care providers and adjusted the rates of pay to address the cost-of-living increase to mitigate the risk of capacity deficit going forward.

Sefton recognise that without a period of adequate recovery or reablement, there is a risk of over prescribing long-term care provision. Within our BCF plan and UEC recovery planning, is a commitment to level up reablement provision to meet demand, allowing for an adequate assessment of need to take place in the residents own home. The aim of this is to reduce demand on domiciliary care services. The community bed based intermediate care operates a discharge to assess and recovery model so that all individuals have access to therapy and a period of recovery before deciding about long-term placement. Our aim is getting more people referred into home-based services to reduce the burden of community bed provision and limit the risk of overprescribing.

We do not envisage there to be any gaps within our planned provision, however, there continues to be a risk of patients navigating inappropriate pathways which could be detrimental to their recovery and independence. This is the focus of our improvement work for 23/24.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Sefton has a multitude of admission avoidance services at multiple touch points across healthcare to support people to stay in their usual place of residence. The 2hr Urgent Community Response provides rapid assessment and triage of 9 clinical conditions as well as acute illnesses and infections that can be supported in the community by a range of services such as the Integrated Community Reablement and Assessment Team (ICRAS), the Community Respiratory Team, IV Therapy Team and the Acute Visiting Service (AVS) that can respond with 2 hours of referral 7 days, 08:00-20:00. Both residential and nursing Care Homes can call the AVS directly to ask for clinical advice and visit a patient within 2 hours to treat or onward refer to the most appropriate service. Any of the services within the UCR will act as a community case finder for the Acute Respiratory Infection, Frailty or Heart Failure Virtual Wards for those that may require admission but can be managed at their usual place of residence. However, any healthcare professional will be able to refer into the virtual ward from primary, community or secondary care via the UCR, including paramedics. All virtual wards will support Early Supportive Discharge from hospital. The UCR also

includes 48-hour reablement support delivered by VCSE organisations to provide reablement as well as wraparound support and includes support which also includes financial, housing, adaptations, counselling, addition support amongst others to enable people to remain or gain their independence.

Sefton have commissioned a falls pick up service for all level 1 falls which operates 24/7 basis and a Sefton Emergency Response Vehicle to respond to level 2 falls. These services are integrated into the 2hr UCR service and community specialist falls service. These services respond to self-referral, health professional referral and care home referrals.

Sefton are expanding pathways that can be managed in the community that currently only exist as an in-patient stay in an acute hospital. Patients in Sefton can now have IV antibiotics for cellulitis, which would have resulted in a hospital stay for a minimum of 5 days. Other IV antibiotic pathways are being progressed to include UTI's, upper and lower respiratory infections that require IV therapy and also sub-cut fluids to support dehydration in Care Homes.

Sefton will be implementing Integrated Community Teams (ICT) in the north of the borough to mirror the ICTs in the south. This will provide a proactive, integrated multidisciplinary approach including using a case finding IT solution to identify those at most risk of hospital admission and prioritise those with the greatest needs. The ICTs will expand to a whole family approach and will support all ages including children. This will be a fully integrated service with physical and mental health, social, voluntary, police and housing organisations working together to provide proactive support to families across Sefton.

Acute Respiratory Infection hubs implemented by the PCN during the previous winter have continued to run in Sefton and have expanded into additional pathways such as ENT, cellulitis and soon to expand into a more general urgent care hub for primary care presentations. We're planning to utilise these hubs to step-up to the virtual wards and the UCR as well as step down and taking a holistic approach to care by onward referring into the ICT or the 48hr reablement to promote independence and reduce risk of crises occurring in the future.

Sefton has a High Intensity User (HIU) service that supports people with mental health, addiction and complex lives or complex health needs that requires an MDT approach to reduce reliance on urgent and emergency care services. This service has expanded into frequent user of community mental health services and via the ICTs we are currently working with people using GP practices frequently to provide additional support from a psycho-social perspective. These HIU services encourage integration of services by coordinating MDT's individual and tailored to individual patient needs to deliver holistic care to the individual and their family or/and carer. Sefton have also commissioned Crisis Cafés to ensure that individuals have support out of hours and at weekends.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

. With the establishment of the Transfer of Care Hub model utilising BCF funds, it is anticipated will that decision making regarding discharge pathways will switch from a hospital prescribed approach to a MDT led by Social Care and Community Health providers challenging all decision for bed based care. This systematic change with increased reablement offers, it is expected will enhance the numbers of patients being discharged on a pathway 1. The Discharge Fund is being used for a range of schemes to support discharge on pathway 0 and 1, such as voluntary sector co-ordination, carers support and personal health budget. This includes the provision of 'Carers Cards' which are issued predominately for Pathway 0 discharges and used by people to make one-off purchases to facilitate and support their discharge. The funds are loaded onto a pre-paid card which allows them to purchase essential items to maintain independence. This scheme is operated by Sefton Carers Centre in order to provide a further method of supporting Carers.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Monthly profiles for hospital discharge and community demand reflect current demand i.e. latest available data (22/23 actuals). Current proportions of discharges for Sefton patients at LUHFT and S&O were then applied to split hospital discharge demand by provider.

For 2hr UCR, the latest monthly data available in 2023 was used to forecast demand for 23/24 and historical profiles of activity from the MCFT ICRAS service was then applied.

Capacity has been set to match demand, by this we mean we maximise the amount of capacity we are able to purchase to budget but do continue to manage this through our Market Sustainability plan.

We have continued to fund those services that made the biggest impact on demand through a longer-term approach reflected in the plan; for example, Discharge Hubs, 7 day working and block bookings.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Our BCF is supporting a number of schemes that will ensure that the individual is discharged to their usual place of residence. Primarily the function of the Transfer of Care Hubs (or Discharge Hubs as they a known locally) will ensure that a Multi-Disciplinary Team respond and review all pathway routes for individuals being discharged from Hospital. The expectation is that with the transfer of care prescribing a discharge pathway as opposed to the Hospital Ward will strengthen this agenda. This system approach, alongside with strengthening of our reablement offer, should ensure an increase in number of individuals being discharged to their home. This alongside with other schemes such as the co-ordination of the voluntary sector, a discharge grant and closer alignment of the Care Centra, the expectation is that Long Length of Stay numbers will reduces and individuals being discharged either to pathway 0 or pathway 1 will increase across our system.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Sefton Place have adhered to the High Impact Change Model (HICM) principles envisaged by the LGA, NHS England and ADASS (2019) in their approach to the implementation of IBCF funded schemes relating to discharge of individuals from hospitals. Providing personalised care and support is integral to the aims and values of Sefton Place anyhow, and Sefton Adult Social Care have adopted a “three conversation” model to enhance a strength based approach. This three conversation model, has been influential in the Transfer of Care Hubs plans, with co-production between all partners to ensure clarity of the roles and responsibilities in implementing this model being defined in a operational framework document. Whilst

the ethos of “valuing patients time” is central to this model, the education and approach of the three conversations model will hopefully ensure the individual being discharged is central to all decision making around their discharge. At present the Local Authority and Community Health Provider have completed information to be circulated across the Trusts educating all NHS staff to the “three conversation” model and are in the process of completing workshops across the system to emphasise the need of providing personalised care and support to enhance outcomes for patients.

In terms of how as a system we are collating feedback from individuals, we are utilising our local Healthwatch offer to independently gain feedback adopting a Think Local Act Personal (TLAP) approach (the use of I and We statements). This information and associated learning will be not only be shared across the system with key stakeholders. With a mixture of focus groups and questionnaires it is hoped that Sefton Place can measure how well the IBCF Sefton Place funded schemes are adhering to the principles of HICM and supporting that correct decisions are being made for individuals being discharged. Data has been shared with Healthwatch who are in the process of contacting patients discharged across pathway’s one, two and three to evaluate how well Sefton Place are adhering to the HICM.

In terms of the specific schemes originally included in the BCF we would provide the following narrative:

1. Early Discharge Planning – Transfer of care hub pilot initiated at LUHFT which identifies the patient at the front door and case manager supports the patient throughout the hospital spell until early discharge. Transfer of care hub model to be standardised across C&M and is currently a priority scheme within the ICB workstreams. Acute trusts are implementing Optica which will assist with tracking and discharging patients when ready. Daily board rounds remain in place to identify patients who have NCTR and who are ready for discharge. Sefton have continued to support the acute trusts with a Nurse Director for urgent care and system flow and Senior manager in LA to provide leadership in weekly long length of stay reviews and NCTR reviews.

2. Monitoring and responding to system demand and capacity – Weekly monitory of capacity and demand in place via the CIPHA team. There has been an intermediate care capacity, demand and outcomes dashboard developed in collaboration with all 9 places across C&M. Data flow was due to go live on 6th July and this will give each place real time information regarding capacity and inform commissioning decisions. Sefton currently do not have a capacity deficit within intermediate care services.

3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge – Daily MDT review in place to support discharge from the acute trusts and the community bed base. There is a weekly system wide bed board meeting with all partners to support and expedite discharge. There is a regular monthly community bed MADE to assist with flow. Transfer of care hub developed in LUHFT and improvement work commenced in line with C&M ICB UEC team to standardise the offer.

4. Home First/Discharge to Assess - process support/core costs – There is currently a value for money service review of reablement services led by Sefton Local Authority, which plans to redirect resource and increase reablement capacity ahead of Winter 23/24. There is improvement work required to integrate health and social care provision seamlessly to support patients home prior to describing care needs. This is a key priority for Sefton and aligns directly to the UEC recovery plan and C&M Tier 1 improvement plan. LUHFT has an offer of enhanced ECIST support to improve discharge and home first is a key work area. Sefton have reached out to benchmark against intermediate care front runners and neighbouring places to agree areas for improvement. The LA have initiated a review of the joint health and social care intermediate care strategy to base line progress to date. This will inform our continual improvement going forward.

5. Flexible working patterns (including 7 day working), discharge services and hospital avoidance services operate on a 7 day working basis. There is ongoing improvement work with the ICB C&M UEC team to look at in hospital processes and reduce variance at weekends which is a key area for improvement in Sefton.

6. Trusted Assessment – Sefton have commissioned a trusted assessor approach within reablement services and have trusted assessors within health services. There is improvement required to increase competency, capacity and capability within discharge to assess process (completion of checklists and DST’s) within local MDT’s.

7. Engagement and Choice – Sefton have additional brokerage function funded utilising Hospital Discharge Funds to assist engagement with families and carers and source appropriate care arrangements to facilitate discharge.

8. Improved discharge to Care Homes – In terms of placements, Sefton have less numbers of individuals being discharged into care homes. Where an individual is being discharged, we have appropriate operational and contractual arrangements in place to ensure this can be facilitated on the same day, seven days a week.

9. Housing and related services – Sefton have commissioned an organisation to support individuals who are deemed to be either homeless on admission or have complex housing issues. This organisation works closely with emergency departments across the Sefton footprint to ensure hostel accommodation is sourced.

10. Red Bag scheme – This scheme would require a relaunch due to the loss of red bags returning to care homes on discharge.

Sefton Place have been working with C&M ICB to identify areas of focused improvement which align to the HICM.

The main areas for improvement include,

Increase capacity, Improve and embed a consistent home first approach. Including a clearer reablement strategy, particularly for frail older people.

Implement a consistent discharge to recover and assess process across Sefton Place utilising the trusted assessor model.

Improve consistency of discharge processes via a transfer of care hub model. The ICB UEC team are looking to standardise this approach across C&M footprint. Work has already commenced in LUHFT and will be implemented in MAWL hospital trust.

Standardise data reporting across intermediate care provision at place to track and match capacity and demand.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Sefton Place has utilised the Integrated Better Care Fund to promote schemes that encourage co-operative working across organisations to secure the safe and timely discharge of patients (as per schedule 3 of the Care Act). Sefton Adult Social Care are completing proportionate and appropriate assessments as per the Care Act to ensure no individuals remain an inpatient longer than they need to be. These proportionate assessments allow for a long-term assessment (or conversation three as they known locally) to take place outside of hospital. The IBCF has funded an additional bed base within access to a MDT setting to facilitate discharge flow, in circumstances when an individual's care may not be immediately available or the individual may need a fuller assessment. This fulfils the remit of the Care Act in as much as it ensures that no long-term decisions about an individual's care is made in a long-term bed and that the focus is always on the individual returning to live independently, as they can, in a community setting.

Furthermore, the additional schemes that have been funded by the Hospital Discharge Grant, that now sits in the IBCF are very much centred on a strength-based approach, as per the narrative of the Care Act and emphasises individuals returning to their usual place of residence to recover rather than a bed in a alternative setting. The ethos of these schemes is that individuals have a bed already and that is in their own home. For instance, the monies have been utilised to fund schemes with the Sefton Place Voluntary Sector and Carers Centre, which support individuals to be discharged home without the resilience or potential wait for a long-term commissioned support from statutory services.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Better Care Fund provides funding to Sefton Carers Centre. The Sefton Carers Centre provides free advice and guidance, emotional and practical support, training and a range of holistic therapies for unpaid carers living in Sefton. This includes providing Carers assessments, supporting Direct Payments and the use of Personal Health Budgets and supporting Children and Young People through Transition. They are a key stakeholder in designing the discharge hub and have a specific hospital discharge service as part of the discharge funding.

The Pre-paid card accounts support the Council in delivering improved administration arrangements for the monitoring of direct payments including annual reviews and audit requirements ensuring Care Act compliance and supporting the Council in identifying breaches in direct payment agreements due to mismanagement of the account.

This service gives people greater choice and control by allowing people to choose and purchase support services by means of a Direct Payment, offering the individual a simpler mechanism to manage their direct payment, and meet their obligations to submit information to the Council.

Benefits include;

- It is used in the same way as a debit card, but it has a predefined amount of cash loaded on it by the Council.
- The card can be used to pay for Personal Assistants (PA), agency or other Direct Payment agreed costs by using the online banking facilities that the card provider offers.
- You cannot go overdrawn on your prepaid card account.
- Reduces paperwork - Reporting facilities within the system helps to improve the information that is reported back to the Council
- Enables the Council to support the client to make payments.
- Enables the Council to have oversight in real time, identifying any issues and offering support.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Housing and our strategic approach: -

The Strategic Housing Commissioning Group has been established to ensure close strategic and operational alignment between Housing Services, both Children's and Adult Social Care Services and Health.

The group has been set up as a response to the ongoing difficulties in sustaining needs led accommodation to support both Children's & Adults Social Care and Health.

The Strategic Housing Commissioning Group overarching aims are to:

- Promote a greater understanding of the role of each of the services.
- Ensure that housing is actively engaged in helping to meet specialist housing need in the borough as per Sefton's Housing Strategy 2022 -27.
- The group will ensure that there is a clear and robust route to the housing market that is based on:
    - Needs identified through ASC Housing Panel, the CSC Accommodation Strategy (ASC Market Position Statement & Children's Sufficiency Strategy) and health.
    - Business cases
    - Approved models of care and support
- Ensure strategic planning and a coordinated approach to the housing and support needs of vulnerable residents.
- Evaluate opportunities for greater efficiencies and ongoing service improvements, including the resolution of operational issue in a managed way.
- Evaluate and manage grant funding, potential capital and disabled facilities grant opportunities with a view to furthering the joint objectives of the group.
- Providing oversight of the Joint Housing Protocol (Children's Services and Housing) requirements covering: 1 Care Experienced Young People, 2 Homeless 16- & 17-Year Olds, 3 Intentionally Homeless Families, 4 No Recourse to Public Funds Families (supported by Children's Services who obtain status that provides access to public funds and services).

The Strategic Housing Commissioning Group will fulfil the following functions:

- Provide a strategic clear, transparent, route to market for accommodation-based service need within Sefton as per CSC, ASC health needs.
- Develop a prospectus of the requirements that will be shared with the market based on the needs analysis provided by CSC, ASC, and commissioning colleagues. Linked to sufficiency strategy and improvement plans.
- Review all offers of accommodation against the agreed needs. The group will consider all offer with a view to making recommendations to ECG.
- All new social care accommodation provided by an external body should be taken through this group without exception.

- Build upon strategic links with RP's, developers, CVS, and the private sector.
- Ensure appropriate revenue budget is Available.
- Collaborating with developers and our planning process to ensure we are clear on what is needed, and nominations rights are considered.
- To support Cared for Children and Care Experienced Young People who are the responsibility of Sefton Council to make a successful transition from care to adulthood and independent living.
- Support Sefton's Housing Strategy Action plan with a focus on the following themes contained within it:
- Enabling people to live independently.
- Tackling Barriers to obtaining suitable housing for the most vulnerable and ensuring equal access to housing services

The outcomes of the Housing Panel look to achieve are as follows:

- One clear process that can support the council with its strategic aims in delivering accommodation requirements that meet ASC, CSC and health needs.
- Supporting the delivery of the Housing Strategy and priority themes
- Ensuring that Cared for Children and Care Experienced Young People have access to a range of supported and independent accommodation opportunities that improves their life chances and outcomes.
- Transparency (mitigate against challenge)
- Agree priorities (assess sites and needs against one another)
- Review potential developments across the borough to see if needs can be met.
- Produce regular progress reports for ECG and Cabinet Members.
- Develop a culture of positive challenge on requirements and look at alternative solutions and innovation.
- Move away from a provider led market of offers of accommodation.
- Develop strategic internal processes,
- Launch event and subsequent market engagement events bi-annually.
- Strategic partner list approved.

Accommodation:

Children's requirements:

- **Residential Homes (2/3/4/5 bedroom) registered by Ofsted.**

Cross over

- **Care experienced children (current model expanded)**
- **Semi-independent age 16-18**
- **Semi-independent age 18-24**
- **Young parent and child accommodation**

Adult's requirements: -

- **Supported Living (Learning Disabilities and or Autism & Mental Health)**
- **Mental Health Provision including both long- & short-term accommodation**

- **Extra Care Accommodation (Older persons/intergenerational)**
- **Extra Care model (Learning Disabilities and or Autism & Mental Health)**
- **Homelessness provision**

Extra Care Housing:

Extra care housing is specialist housing provision designed for older people that combines accommodation with care and support services to offer safe, private and secure accommodation whilst allowing service users to retain their independence of having their own home and reduce our reliance on residential homes.

Sefton currently has two schemes and an ambition to deliver 1,306 units required by 2,036 (approximately 15 schemes). 5 such schemes are currently at the planning stage and will deliver c500 units over the next 3 years.

A nominations policy, process and system has now also been consulted on with Sefton residents with the policy aiming to promote independence and well-being; facilitate a balanced, vibrant and sustainable community for residents with care and support needs within the setting of extra care housing which will play a key role in preventing and avoiding admissions to residential care and hospitals and contribute to our preventative agenda.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes, the RRO has allowed us to introduce discretionary funding grants, these allow clients who's required adaptations my exceed the £30k threshold (not available for residential social landlord clients) to be implemented.

Clients who qualify for this additional funding, may receive the initial mandatory grant of £30k and costs above this may be met via a separate application (discretionary grant funding application). A land charge is placed against the property in connection with the mandatory grant of £30k and will be removed ten years from the works certified completion date and a second land charge is registered for the discretionary element, this second land charge is

registered on a permanent basis until the property is sold or transferred. This helps to protect DFG funding by ensuring repayment is received.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

There is no limit for the use of Discretionary funds in place. This type of funding is to assist clients where necessary and in accordance with the relevant conditions which are in place, whilst there are sufficient DFG funds available.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

As a Sefton Place Partnership, we recognise there are stark differences in the quality and length of life across Sefton and that we need to work together to prioritise those who stand to gain the most. This is one of the three priorities of our place plan which defines integrated delivery for Sefton. Big differences in living standards and life chances cause big differences in health, including how long someone can expect to live in good health. Sefton has the second most divided distribution of wealth and poverty in England, just behind Kensington and Chelsea. The big causes of long-term illness in Sefton are smoking, obesity, poor quality food, not being active, alcohol use, diseases affecting the heart, brain and blood vessels, lung disease, cancers, mental illness and injury. About half of this ill-health can be prevented and are the biggest cause of ill health in Sefton.

To impact on this priority over the next two years the plan commits us to the following:

Proportionate universalism

The resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need. This aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest.

Core20PLUS5

A national NHS England approach to reducing inequalities that is focused on the most 20% deprived communities, those groups who suffer particular disadvantage, and across priority areas for action and for both adults and children. We know that Sefton is more unequal than most of England with large gaps between the expected lifespan of residents who live in the richest and poorest parts of the borough.

There will be cumulative benefits beyond health outcomes of our adopting both approaches, and by prioritising and targeting resources in a joined-up, evidence-based way. For example, this should help to reduce future demand on heath and care services, which ties in with the

role all partners have in supporting early intervention and prevention. We are therefore embracing a “whole population, whole partnership” approach to reducing health inequalities as part of our plan.

The following section details some of the key areas of work our place plan commits us to and that the Better Care fund will act as an enabler to.

This includes commitment to developing an expanded offer for CYP and their families/carers with emotional health and well-being needs, with a specific focus on children in care that reflects a partnership approach to the role of corporate parent, and development of support for those aged 19-25.

Integrated practice that is supported by co-location, with opportunities for integrated induction of staff, strengthened through shared training, shadowing and observation across partners, team meetings, case management discussions and matrix management approaches.

Shared access to data and IT systems in order to collate evidence of early help across Sefton Partnership, ensuring it is utilised to target and identify genuine gaps in provision. Such gaps will be prioritised for service investment through adopting a whole pathway approach, within a shared outcomes framework.

Embed measures to improve health and reduce inequalities, including a continued focus on CVD, obesity, diabetes and smoking cessation. Accelerate preventative programmes that engage those at greatest risk of poor health outcomes using the pregnancy register to target immunisations and other health messages, including the rollout of a treating tobacco dependency programme at providers accessed by Sefton women and the mobilisation of a Sefton stop smoking in pregnancy group.

Development of Integrated Care Teams (ICT) that encompass a ‘Whole Family Approach’ working in partnership with Mersey Care, Alder Hey, Adult Social Care, Children’s Social Care and the VCF sector to develop and enhance the existing model to reflect an all-age focus.

Co-produce an employment pathway that provides individuals with meaningful training, volunteering and employment opportunities that lead to paid employment, working in partnership with Department of Work and Pensions, colleges, advocacy organisations, Get Involved Group, and VCF sector.

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Sefton
Completed by:	Eleanor Moulton
E-mail:	Eleanor.Moulton@Sefton.gov.uk
Contact number:	7983939062
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Ian	Moncur	Ian.Mocur@sefton.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Deborah	Butcher	Deborah.Butcher@Sefton.gov.uk
	Additional ICB(s) contacts if relevant	Ms	Rebecca	McCullough	Rebecca.McCullough@southseftonccg.nhs.uk
	Local Authority Chief Executive	Mr	Dwayne	Johnson	Dwayne.Johnson@Sefton.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Deborah	Butcher	Deborah.Butcher@Sefton.gov.uk
	Better Care Fund Lead Official	Ms	Eleanor	Moulton	Eleanor.Moulton@Sefton.gov.uk
	LA Section 151 Officer	Mr	Stephan	Van Arendsen	Stephan.VanArendsen@sefton.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Sefton

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£4,823,370	£4,823,370	£4,823,370	£4,823,370	£0
Minimum NHS Contribution	£27,931,587	£29,512,515	£27,931,587	£29,512,515	£0
iBCF	£15,725,903	£15,725,903	£15,725,903	£15,725,903	£0
Additional LA Contribution	£497,100	£497,100	£497,100	£497,100	£0
Additional ICB Contribution	£3,872,380	£3,660,153	£3,872,380	£3,660,153	£0
Local Authority Discharge Funding	£2,204,747	£3,659,880	£2,204,747	£3,659,880	£0
ICB Discharge Funding	£1,998,225	£2,718,153	£1,998,225	£2,718,153	£0
Total	**£57,053,313**	**£60,597,074**	**£57,053,312**	**£60,597,074**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£7,937,365	£8,386,620
Planned spend	£11,714,964	£12,445,640

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£14,352,951	£15,165,328
Planned spend	£14,679,607	£15,461,574

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	213.2	176.4	204.2	198.6

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,988.5	1,924.4
	Count	1371	1327
	Population	65158	65158

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%	92.8%	92.4%	91.6%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	622	606

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Sefton

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.
Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Monthly profiles for hospital discharge and community demand reflects current demand i.e. latest available data (22/23 actuals). Current proportions of discharges for Sefton patients at LUHFT and S&O were then applied to split hospital discharge demand by provider. For 2hr UCR, the latest monthly data available in 2023 was used to forecast demand for 23/24 and historical profiles of activity from the MCFT ICRAS service was then applied. Capacity has been set to match demand.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! | Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr.23	Mai.23	Jun.23	Jul.23	Aug.23	Sep.23	Okt.23	Nov.23	Dez.23	Jän.24	Feb.24	Mär.24
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	10	6	6	12	11	13	21	12	10	9	10	16
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		8	14	19	21	18	22	24	24	28	28	34	37
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement at home (pathway 1)	35	22	32	21	28	23	22	23	25	29	28	33
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		35	22	32	21	28	23	22	23	25	29	28	33
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	60	75	62	56	74	76	59	67	82	74	60	77
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		96	110	105	98	106	96	95	122	86	102	109	121
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	9	8	11	9	10	10	9	13	10	8	9	9
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		9	8	11	9	10	10	9	13	10	8	9	9
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	10	10	10	23	7	7	4	7	6	6	8	21
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	33	24	26	25	30	22	21	30	38	18	23	29
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		92	103	100	126	62	92	85	66	84	142	147	108
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	25	19	34	31	25	27	19	26	31	37	18	27
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST		35	35	33	30	40	34	27	19	32	27	25	34
Totals	**Total:**	1509	1951	1588	1565	1495	1509	1378	1472	1561	1711	1674	1842

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr.23	Mai.23	Jun.23	Jul.23	Aug.23	Sep.23	Okt.23	Nov.23	Dez.23	Jän.24	Feb.24	Mär.24
Social support (including VCS)	407	421	407	421	421	407	421	407	421	421	380	421
Urgent Community Response	340	316	350	251	255	261	312	285	340	350	190	231
Reablement at home	61	60	60	75	58	72	67	66	50	77	75	87
Rehabilitation at home	122	142	174	142	123	128	137	155	168	204	181	233
Reablement in a bedded setting	71	64	69	73	64	74	65	71	46	72	69	80
Rehabilitation in a bedded setting	9	11	8	10	5	7	7	7	8	11	11	9
Other short-term social care	23	19	30	29	30	26	29	34	31	20	29	27

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr.23	Mai.23	Jun.23	Jul.23	Aug.23	Sep.23	Okt.23	Nov.23	Dez.23	Jän.24	Feb.24	Mär.24
Social support (including VCS)	Monthly capacity. Number of new clients.	18	20	25	33	29	35	45	36	38	37	44	53
Reablement at Home	Monthly capacity. Number of new clients.	70	44	64	42	56	46	44	46	50	58	56	66
Rehabilitation at home	Monthly capacity. Number of new clients.	156	185	167	154	180	172	154	189	168	176	169	198
Short term domiciliary care	Monthly capacity. Number of new clients.	18	16	22	18	20	20	18	26	20	16	18	18
Reablement in a bedded setting	Monthly capacity. Number of new clients.	10	10	10	23	7	7	4	7	6	6	8	21
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	125	127	126	151	92	114	106	96	122	160	170	137
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	60	54	67	61	65	61	46	45	63	64	43	61

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
50%	50%	
50%	50%	
90%	10%	
	100%	
80%	20%	
100%		
100%		

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr.23	Mai.23	Jun.23	Jul.23	Aug.23	Sep.23	Okt.23	Nov.23	Dez.23	Jän.24	Feb.24	Mär.24
Social support (including VCS)	Monthly capacity. Number of new clients.	407	421	407	421	421	407	421	407	421	421	380	421
Urgent Community Response	Monthly capacity. Number of new clients.	340	316	350	251	255	261	312	285	340	350	190	231
Reablement at Home	Monthly capacity. Number of new clients.	61	60	60	75	58	72	67	66	50	77	75	87
Rehabilitation at home	Monthly capacity. Number of new clients.	122	142	174	142	123	128	137	155	168	204	181	233
Reablement in a bedded setting	Monthly capacity. Number of new clients.	71	64	69	73	64	74	65	71	46	72	69	80
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	9	11	8	10	5	7	7	7	8	11	11	9
Other short-term social care	Monthly capacity. Number of new clients.	23	19	30	29	30	26	29	34	31	20	29	27

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
50%	50%	
100%		
50%	50%	
90%	10%	
90%	10%	
100%		
50%	50%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Sefton

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Sefton	£4,823,370	£4,823,370
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£4,823,370**	**£4,823,370**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Sefton	£2,204,747	£3,659,880

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Cheshire and Merseyside ICB	£1,998,225	£2,718,153
Total ICB Discharge Fund Contribution	£1,998,225	£2,718,153

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Sefton	£15,725,903	£15,725,903
Total iBCF Contribution	**£15,725,903**	**£15,725,903**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Sefton	£497,100	£497,100	Advocacy - new combined contract being commissioned
Total Additional Local Authority Contribution	**£497,100**	**£497,100**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Cheshire and Merseyside ICB	£27,931,587	£29,512,515
Total NHS Minimum Contribution	**£27,931,587**	**£29,512,515**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Cheshire and Merseyside ICB	£3,872,380	£3,660,153	This relates to funding in excess of the required plus
Total Additional NHS Contribution	**£3,872,380**	**£3,660,153**	
Total NHS Contribution	**£31,803,967**	**£33,172,668**	

	2023-24	2024-25
Total BCF Pooled Budget	**£57,053,313**	**£60,597,074**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

DFG surplus carried forward from 22/23 allocation was £562,677. Making the total accumulated surplus for all prior years as £10.254m carrying forward into 23/24. DFG spend is part of long term capital programme and surplus from prior years is re-profiled into future years

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Sefton

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£4,823,370	£4,823,370	£0	£4,823,370	£4,823,370	£0
Minimum NHS Contribution	£27,931,587	£27,931,587	£0	£29,512,515	£29,512,515	£0
iBCF	£15,725,903	£15,725,903	£0	£15,725,903	£15,725,903	£0
Additional LA Contribution	£497,100	£497,100	£0	£497,100	£497,100	£0
Additional NHS Contribution	£3,872,380	£3,872,380	£0	£3,660,153	£3,660,153	£0
Local Authority Discharge Funding	£2,204,747	£2,204,747	£0	£3,659,880	£3,659,880	£0
ICB Discharge Funding	£1,998,225	£1,998,225		£2,718,153	£2,718,153	£0
Total	**£57,053,313**	**£57,053,312**	**£1**	**£60,597,074**	**£60,597,074**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,937,365	£11,714,964	£0	£8,386,620	£12,445,640	£0
Adult Social Care services spend from the minimum ICB allocations	£14,352,951	£14,679,607	£0	£15,165,328	£15,461,574	£0

Checklist

Column complete:

Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):
58, 59, 60, 61,

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Virtual Ward/CC2H	Virtual Ward Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
1	Virtual Ward/CC2H	Virtual Ward Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		NHS			NHS Community Provider	Additional NHS Contribution
2	Community Matrons	Community Matrons Team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
3	Children's Community Nursing Outreach	Children's Community Nursing Outreach Team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
4	Community Treatment Rooms	Community Treatment Rooms	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
5	District Nurses(Twilight Nursing)	District Nurses(Twilight Nursing)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
6	District Nurses Out of Hours	District Nurses Out of Hours	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
7	District Nurses Out of Hours	District Nurses Out of Hours - Additional Capacity in Southport & Formby	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution

8	Alcohol Nurse	Alcohol Nurse	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution
9	HALS (Alcohol Liaison)	HALS - Alcohol Liaison Service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution
10	Phlebotomy	Phlebotomy Service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution
11	Respiratory/Community Response Team	Respiratory community response team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
12	Community Heart Failure/Cardiac Rehab	Community Heart Failure/Cardiac Rehab Services	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
13	Community Dietetics (inc Enteral Feeding)	Community Dietetics (inc Enteral Feeding) Service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
14	Community Nursing Team	Children's Community Nursing Team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
15	Community Paediatrics	Community Paediatrics	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
16	Advocacy	Statutory and Community Advocacy Services	Care Act Implementation Related Duties	Other	Advocacy Services				Social Care		Joint	100.0%	0.0%	Charity / Voluntary Sector	Minimum NHS Contribution
16	Advocacy	Statutory and Community Advocacy Services	Care Act Implementation Related Duties	Independent Mental Health Advocacy	Advocacy Services				Social Care		Joint	100.0%	0.0%	Charity / Voluntary Sector	Additional NHS Contribution
16	Advocacy	Statutory and Community Advocacy Services	Care Act Implementation Related Duties	Other	Advocacy Services				Social Care		Joint	0.0%	100.0%	Charity / Voluntary Sector	Additional LA Contribution
17	Social Work	Additional Social Worker Capacity - Mobile Working	Care Act Implementation Related Duties	Other	Social Workers				Social Care		LA			Local Authority	Minimum NHS Contribution
18	Care Act	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Includes Additional SW/ Safeguarding				Social Care		LA			Local Authority	Minimum NHS Contribution
19	Care Act	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Deprivation of Liberty Safeguards				Social Care		LA			Local Authority	Minimum NHS Contribution
20	Carers Breaks & Respite	Carers Breaks & Respite	Carers Services	Respite services		560	590	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution
21	Carers Card Initiative	Carers Card Initiative	Carers Services	Other	Carer Advice and Support	560	590	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
22	Investment in Sensory Support Eye Clinic Liason	Bradbury Fields Voluntary Service	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
23	Intermediate Care (LH)	Intermediate Care (LH)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		30	30	Number of Placements	Acute		NHS			NHS Community Provider	Minimum NHS Contribution
24	Intermediate Care - Community	Intermediate Care Services	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	Rapid / Crisis Response				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
25	Intermediate Care Services	Intermediate Care Services (North Sefton) Dovehaven/ Birch Abbey	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		35	35	Number of Placements	Acute		NHS			NHS Community Provider	Minimum NHS Contribution
26	GP Call Handling Service	HICM for Managing Transfer of Care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
27	Discharge Planning	Integrated Care Planning and Navigation	Integrated Care Planning and Navigation	Care navigation and planning					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution

28	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		12,500	14,500	Number of beneficiaries	Social Care		NHS			Local Authority	Minimum NHS Contribution
29	Community Equipment Additional	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		12,500	14,500	Number of beneficiaries	Social Care		NHS			Local Authority	Minimum NHS Contribution
30	Home from Hospital	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		8900	9400	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
31	Early Discharge	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		11100	11800	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
32	Intermediate Care - Chase Heys	Intermediate Care - Chase Heys - Therapy Provision	Bed based intermediate Care Services (Reablement,	Other	OT Therapy supporting	14	14	Number of Placements	Community Health		NHS			Private Sector	Minimum NHS Contribution
33	Intermediate Care Worker	Intermediate Care Worker Post - Chase Heys	Workforce recruitment and retention						Social Care		LA			Private Sector	Minimum NHS Contribution
34	Intermediate Care Services	Intermediate Care Services-Chase Heys	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services	Bed-based intermediate care with rehabilitation (to support discharge)		11	11	Number of Placements	Social Care		LA			Private Sector	Additional NHS Contribution
35	End of Life Service SW	End of Life Service - Social Work Lobby Team - Contribution to Post	Personalised Care at Home	Other	End of Life				Social Care		LA			Local Authority	Minimum NHS Contribution
36	Reablement	Reablement - Block Contract Provision	Reablement in a persons own home						Social Care		LA			Private Sector	Minimum NHS Contribution
37	Community Stores Equipment and Adaptations	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		12500	14500	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
38	Adult Social Worker Capacity and Supporting	Lead Practitioners and Social Workers Embedded into Discharge Planning Teams	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
39	Telecare to Support People at Home	Sefton Careline Service	Assistive Technologies and Equipment	Assistive technologies including telecare		4000	5000	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
40	Equipment and Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		4,000	5,000	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
41	DFG	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		623	823	Number of adaptations funded/people	Social Care		NHS			Local Authority	DFG
42	Falls	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Other	Public Health Comissoned Services and CCG	NHS			Local Authority	Minimum NHS Contribution
43	Alder Hey CAMHS	Alder Hey CAMHS Service	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
44	Reablement Rapid Response	Rapid Response Service	Reablement in a persons own home						Social Care		LA			Private Sector	iBCF
45	Contribution to Placements & Packages	Residential Placements	Residential Placements	Supported housing		14	14	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
45	Contribution to Placements & Packages	Residential Placements	Residential Placements	Learning disability		115	115	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
45	Contribution to Placements & Packages	Residential Placements	Residential Placements	Care home		119	119	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
45	Contribution to Placements & Packages	Residential Placements	Residential Placements	Nursing home		66	66	Number of beds/Placements	Social Care		LA			Private Sector	iBCF

45	Contribution to Placements & Packages	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		119200	119200	Hours of care	Social Care		LA			Private Sector	iBCF
45	Contribution to Placements & Packages	Personalised Budgeting and Commissioning	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	iBCF
46	NHS Transfer to Social Care	Residential Placements	Residential Placements	Learning disability		66	71	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
46	NHS Transfer to Social Care	Residential Placements	Residential Placements	Care home		68	72	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
46	NHS Transfer to Social Care	Residential Placements	Residential Placements	Nursing home		38	40	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
46	NHS Transfer to Social Care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		68550	72750	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
46	NHS Transfer to Social Care	Personalised Budgeting and Commissioning	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	Minimum NHS Contribution
46	NHS Transfer to Social Care	Residential Placements	Residential Placements	Supported housing		8	8	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
47	Integration & Transformation	Integration & Transformation	Enablers for Integration	System IT Interoperability					Other	Integration & Transformation	NHS			Local Authority	Additional NHS Contribution
48	Ageing well	Ageing well	Other						Other	National NHS E funded programme	NHS			NHS Community Provider	Additional NHS Contribution
49	Sefton LA Discharge	Facilitated discharge - Complex care support & advanced care planning -	Other						Social Care		LA			Private Sector	Local Authority Discharge
49	Sefton LA Discharge	Improving patient flow - Enhanced Home First	Home Care or Domiciliary Care	Other	enhanced reablement and Dom care and	67150	67150	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge
49	Sefton LA Discharge	Improving patient flow- Transfer fo care hub	Other						Social Care		LA			Local Authority	Local Authority Discharge Funding
50	ICB Discharge	Beds - intermediate care- Additional bed capacity to support step up and step	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		95	95	Number of Placements	Acute		NHS			NHS Community Provider	ICB Discharge Funding
50	ICB Discharge	Beds - intermediate care Medical Cover	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		43	43	Number of Placements	Acute		NHS			NHS Community Provider	ICB Discharge Funding
50	ICB Discharge	Admission avoidance - Extension of 2hr UCR	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Other	Integrated approach	NHS			NHS Community Provider	ICB Discharge Funding
50	ICB Discharge	Facilitated discharge - Complex care support & advanced care planning	Integrated Care Planning and Navigation	Care navigation and planning					Other	Integrated approach	NHS			NHS Community Provider	ICB Discharge Funding
51	Woodlands	Short Term Supported Living	Community Based Schemes	Other	MH step up/down facility				Social Care		Joint	50.0%	50.0%	Private Sector	Additional LA Contribution
51	Woodlands	Short Term Supported Living	Community Based Schemes	Other	MH step up/down facility				Social Care		Joint	50.0%	50.0%	Private Sector	Additional NHS Contribution
48	Ageing well	ICRAS team (Integrated Community, Reablement and Assessment Service) and	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Additional NHS Contribution
48	Ageing well	Reablement Rapid Access service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Local Authority	Additional NHS Contribution

48	Ageing well	Falls pick up service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution
48	Ageing well	VCF sector support for discharge schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Sefton

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	218.8	181.0	207.3	205.0	Reflects current levels of activity and an assumption of -3% being achieved during 23/24. NB. Q4 of 22/23 was based on a forecast using available data.	Sustain additional bed capacity to support step up and step down provision to maximise hospital bed capacity Enhance reablement and domiciliary care provision as well as wider approaches as part of an Enhanced Home First offer, including for those patients with a mental health condition and/or a learning disability
	Number of Admissions	780	645	739	-		
	Population	275,396	275,396	275,396	275,396		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	213.2	176.4	204.2	198.6		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,760.5	1,988.5	1,924.4	Assumption of -3% reduction in 22/23 estimated admissions being achieved during 23/24.	Falls - The Sefton Falls Strategy is being reviewed currently. In Sefton, there are plenty of services to prevent and reduce the impact of a fall on quality of life and longevity such as the 2hr UCR, Home First and Reablement. Falls strategy under review ICT -Develop proactive all age Integrated
	Count	1,905	1371	1327		
	Population	65,158	65158	65158		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are	Quarter (%)	92.4%	92.8%	92.4%	92.0%	Reflects current levels of activity as a baseline for 23/24. NB. Q4 of 22/23 was based on a forecast using available data.	Develop complex care & advanced care planning to support high costs packages of care and 1:1 provision for dementia Enhance reablement and domiciliary care
	Numerator	6,022	6,233	5,906	5,982		
	Denominator	6,519	6,714	6,392	6,502		

		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.4%	92.8%	92.4%	91.6%		provision as well as wider approaches as part of an Enhanced Home First offer, including for those patients with a mental health condition and/or a learning disability Establish a transfer of care hub that
	Numerator	6,022	6,233	5,906	5,715		
	Denominator	6,519	6,714	6,392	6,237		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	621.7	708.1	636.1	606.3	2023-24 plan based on latest figures and dirction of travel over last 12 months.	Sustain additional bed capacity to support step up and step down provision to maximise hospital bed capacity Develop complex care & advanced care planning to support high costs packages of care and 1:1 provision for dementia
	Numerator	407	482	433	420		
	Denominator	65,463	68,069	68,069	69,276		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.7%	90.7%	90.1%	90.0%	2023-24 plan denominator based on recent increase in reablement service starts over latest 4-5 months and numerator based on consistent effectiveness of reablement services .	Enhance reablement and domiciliary care provision as well as wider approaches as part of an Enhanced Home First offer, including for those patients with a mental health condition and/or a learning disability
	Numerator	215	254	236	270		
	Denominator	251	280	262	300		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan

NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

SEND CIB Governance Proposal

11th July 2023

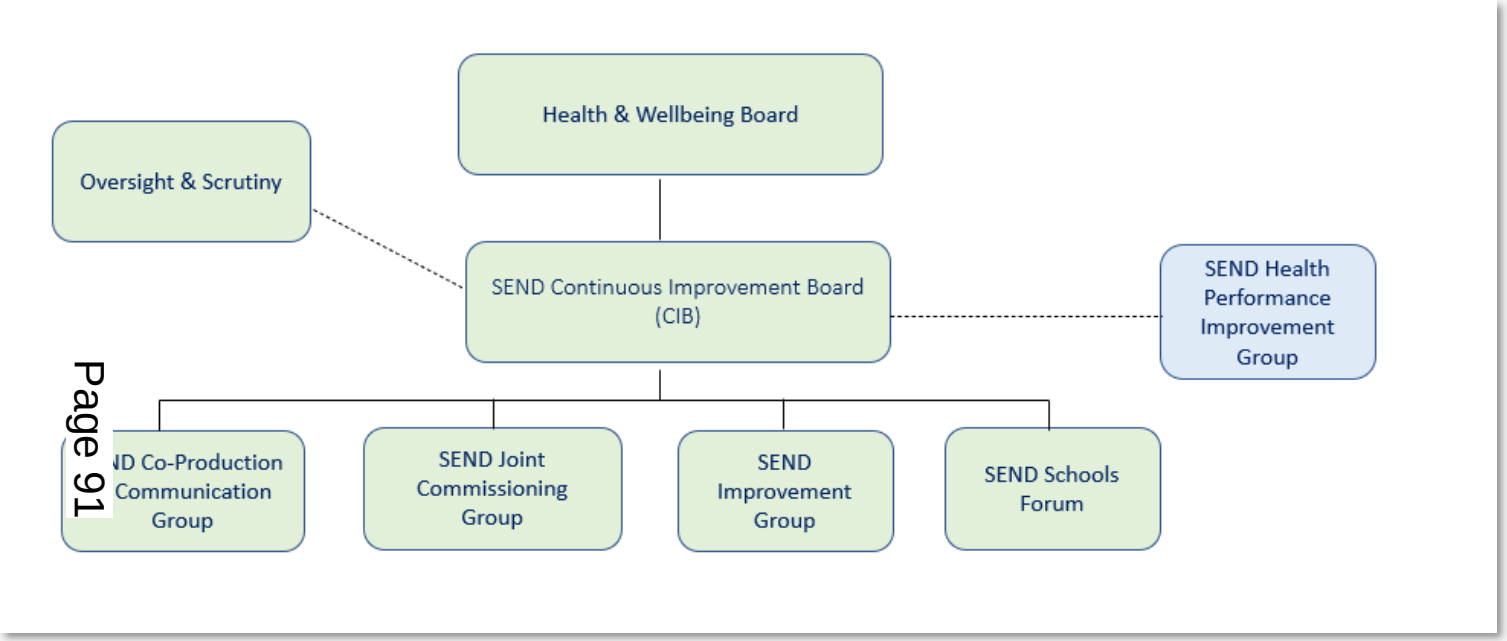
Proposal Rationale & Objectives

Sefton is ambitious for its SEND children & young people to have fulfilling and successful lives so let's match that ambition for the supporting governance structures that enable that ambition.

As well as being the right thing to do, ensuring governance & oversight best practice is in place and being followed is a key area that the inspection will be looking at ***(feedback from Warrington BC)*** so this proposal will:

- Increase the levels of rigour and oversight for the CIB through enhanced service and improvement data.
- Widen the contribution to the CIB agenda by all partners to increase the levels of ownership and accountability and ensure it is clear what their individual contributions are.
- Ensure there is a focus on delivering the decisions made at CIB through effective tracking.
- Increase the pace of delivery of SEND improvements to get quicker impacts on the ground through a more focused and standardised approach to improvement project reporting and risk management.
- Increase capacity of partners working on SEND by reducing related groups/meetings to ensure they are relevant and aligned.
- The Board has a clear view of SEND performance across the local area and an insight to the drivers and causes to enable it to decide on the priorities and areas of focus.

Proposed Improvement Project Reporting



- Performance Management and System Leadership meeting functions taken over by proposed SEND Dashboard and newly convened 'Pre-Board Meeting'
- Terms of reference for CIB to be revised to confirm its oversight and decision-making roles and to be held bi-monthly.
- Adults, Children's & Education lead members proposed to be joint chairs (majority vote required e.g. 2/3).
- Senior leaders from all partners to be standing members of CIB.
- Terms of reference to be revised for each 'delivery group' to align with SEND Improvement outcomes & measures of success.
- Each 'delivery group' to have a standing item on the agenda to report progress against outcomes & measures of success.

All delivery groups have a standardised agenda and action/risk logs

Draft Agenda circulated to Chairs and leads. (3 weeks prior to CIB) → All reports and agenda items submitted. (2 weeks prior to CIB) → CIB pre–board meeting. (1 week prior to CIB) → CIB held bi-monthly. (2 hours) → Post CIB papers distributed. (1 week after CIB)

Agenda Item 6

Proposed CIB Agenda

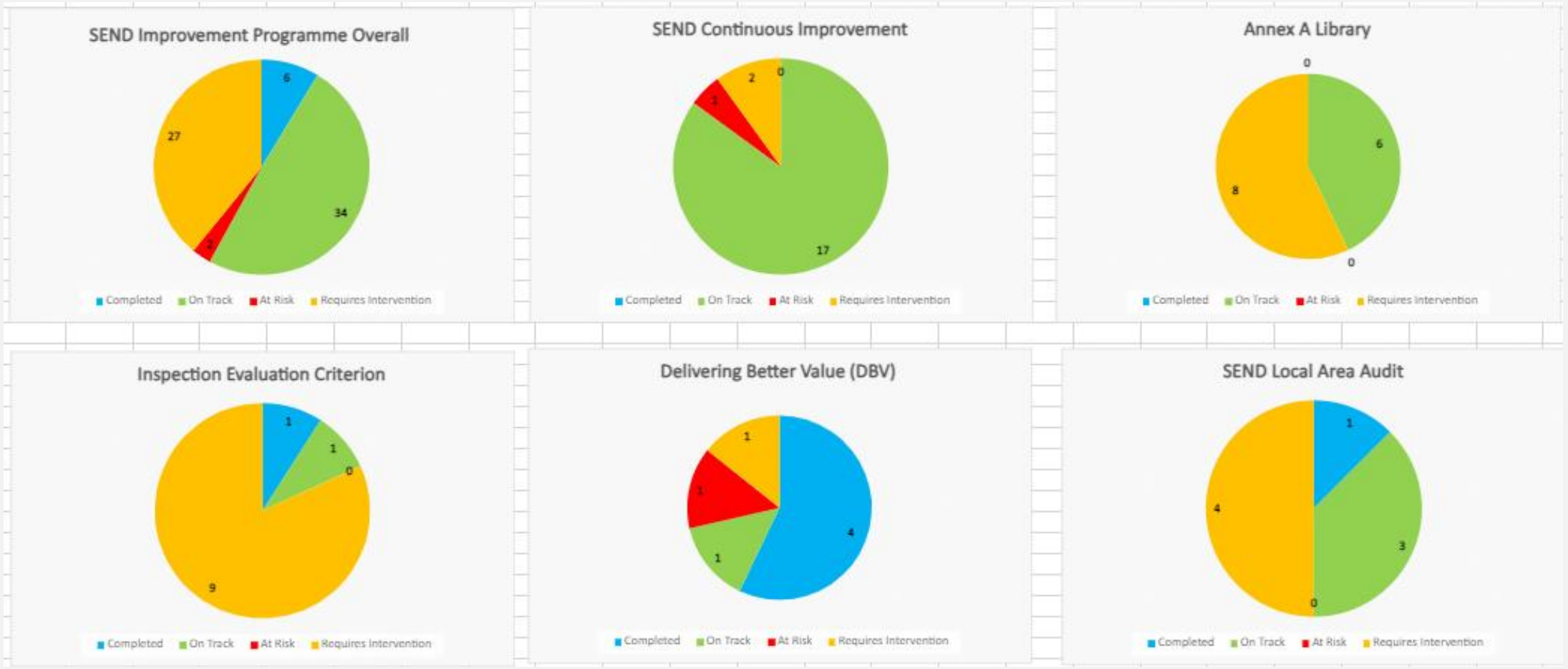
Agenda Item 6

Agenda Item	Owner
Introductions & Apologies	Chair
Review of decision & action log	Strategic Support
Conflicts of interest and confidentiality	Chair/All
Standing Agenda Items	
Voice of the Child/Young Person case study	Rotated - Education/Health/Social Care
SEND Performance Report (Dashboard)-*SEND operational data.*	SEND Manager
PCF date	PCF Chair/Rep
SEN mprovement Group Report	Programme Manager
Joint ommissioning Group Report	Group Lead
Schools Forum Group Report	Group Lead
Co-Production & Communications Report	Group Lead
Focus Area & Sign Off Requests	
Example report	Lead
Example strategy	Lead
AOB	

The proposed revised agenda will consist of four distinct elements:

- Introductions/admin/review of decision log/actions.
- Standing Agenda items.
- Focus area (as identified by the Chair(s)/Board and sign off requests.
- AOB.

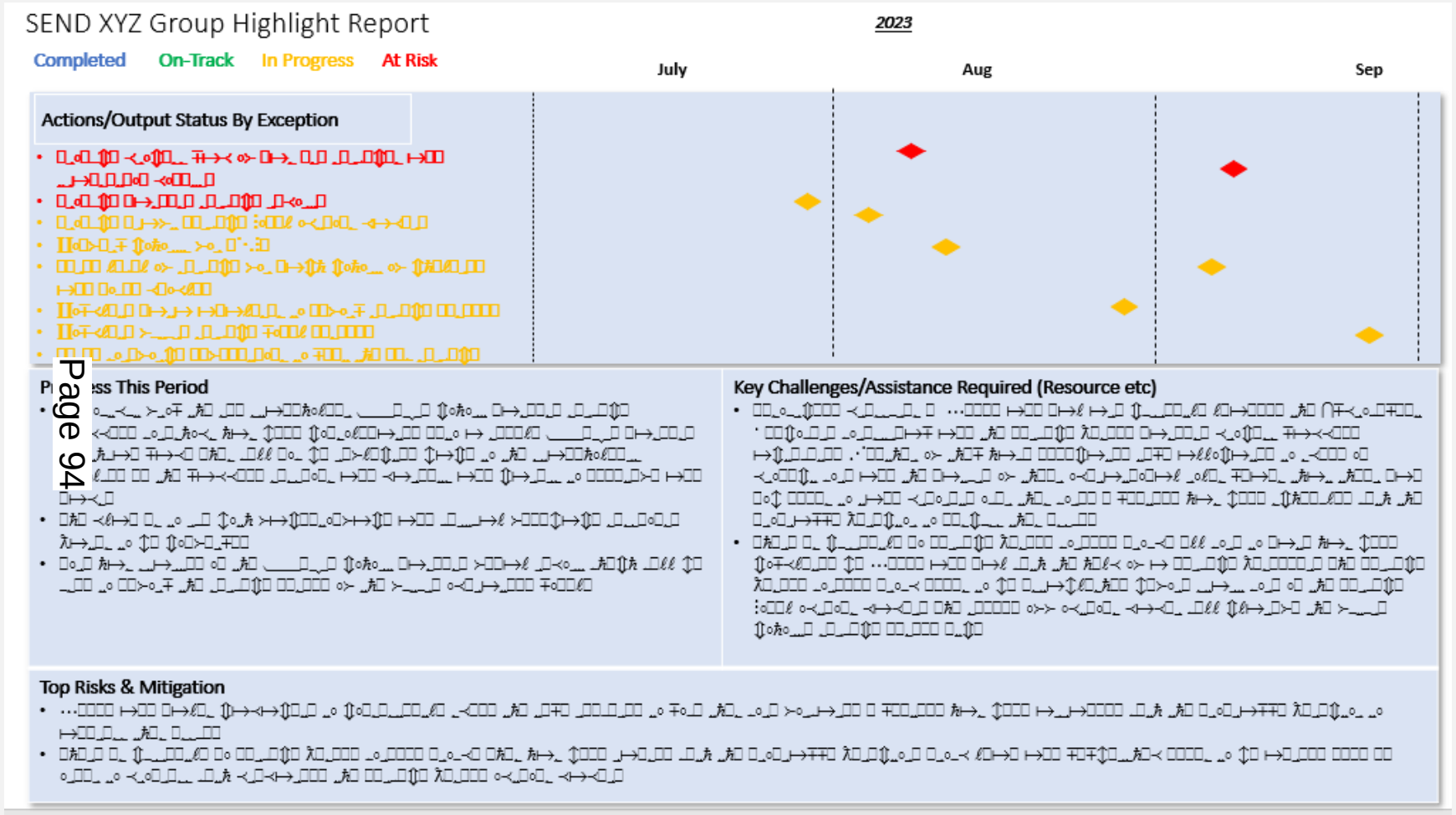
Proposed Delivery Group Reporting



The programme level of reporting will show the status of all actions/outputs across the CIB delivery groups together with a summary for each e.g.:

- 6 completed
- 34 on track
- 27 in progress
- 2 at risk

Proposed Delivery Group Reporting



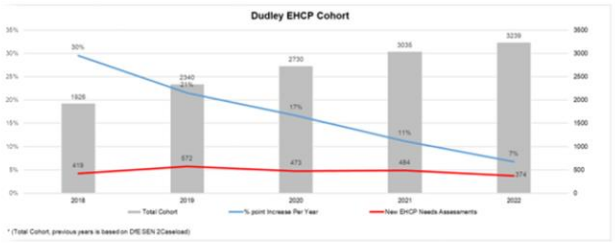
The project/delivery group level of reporting will show the status for each of the four groups as:

- Actions/Outputs due in the next three months status **by exception** together with an update on the reasons for any delay etc.
- Progress in the last quarter in terms of what has been completed/delivered.
- Key challenges/assistance needed such as extra resource or assistance from partners etc.
- Top risks & mitigation which would be those with the potential to delay delivery etc.

SEND Dashboard Suggested Data Sets

(examples are not Sefton data)

EHCPs active as of xxxx



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What is the data telling Us?

- 11%, 296, increase this year against 10% Nationally in 2021.
- <11%, 265 increase year to date.
- Average 12 new EHCPNA requests every week. Compares to 9 per week for previous years
- first issued By DfE age group in 2022;
- 92, 5-10=97, 11-15=67 16+ = 9

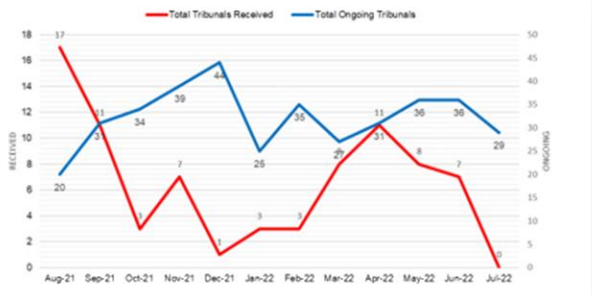
Timeliness - EHC Plans Issued within the 20 Week Statutory Timeframe

Year to 31st August 2022 we were at:
36% (All)
v national rate of 60% for 2021.
(the latest SEN2 published in May 2022).

2022 is not at the same completion rate as 2021 to date, this in part is due to the increase in requests for early years in a concentrated period of time, however further work and scrutiny has been embedded into the SEND team to develop this. Close working with Early Years Service to support change in requests for assessment for the year 2022/23

Currently 14 missed the 20 weeks deadline. This represents a significant improvement in comparison to April figure which had reached over 60.
Breakdown:
0 over 40 weeks
1 over 30 weeks
13 over 20 weeks

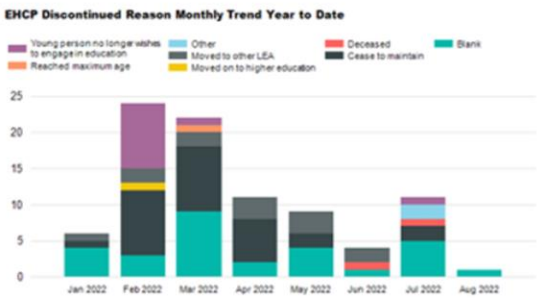
Tribunals

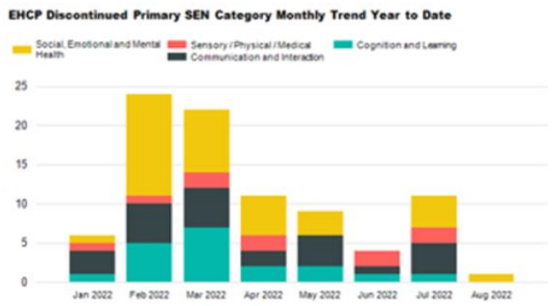


Performance Data - Therapy Services

					Jun-19	Sep-19	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Dec-21	Mar-22
LQR 5	Children's Services Waiting Times – Occupational Therapy	Local	Quarterly	<=8 weeks	8.9	7	0	9	7.6	6.7	6.4	8	9.5	8.2	7.6	5.8
LQR 6	Children's Services Waiting Times – Paediatric Physiotherapy	Local	Quarterly	<=10 weeks	0	5	0	7	8.3	10.8	10.3	10	9.2	10.3	7.6	8.6
LQR 7	Children's Services Waiting Times – Speech & Language Therapy	Local	Quarterly	<8= weeks	0	7	0	7	7.3	6.7	5.6	10	9.4	11.1	9.8	9

EHCP First Issued vs Discontinued (ceased)





Output / Outcome	Objectives	Period		SEN provision SEN with statement or EHC Target England	SEN provision SEN with statement or EHC Actual Dudley		SEN provision SEN without statement Target England	SEN provision SEN without statement Actual Dudley		SEN provision - No SEN Target England	SEN provision - No SEN Actual Dudley
Our children are safe and happy and are engaged in learning	**DfE Attendance and Absence data**										
	Attendance Rate	202021	✗	87%	86.3%	✓	93.5%	93.6%	✗	96.1%	95.[illegible]
	Authorised Absence Rate	202021	✗	11.1%	12.0%	✓	4.5%	4.3%	✗	2.9%	2.[illegible]
	Unauthorised Absence Rate	202021	✓	2.0%	1.8%	✗	2.0%	2.1%	✗	1.1%	1.[illegible]
	Overall Absence Rate	202021	✗	13.1%	13.7%	✓	6.5%	6.4%	✗	3.9%	4.[illegible]
	DfE Suspension and Exclusion data										
	Suspensions Rate	202021	✗	12.98%	13.1%	✗	11.9%	12.6%	✗	2.8%	3.6[illegible]
	Permanent Exclusions Rate	202021	✓	0.1%	0.0%	✗	0.15%	0.17%	✗	0.03%	0.06%

Summary of Decisions Requested

- Approve the proposed revised CIB governance structure and delivery groups.
- Approve the proposed pre and post CIB meeting schedule and function.
- Approve the proposed CIB and supporting group Terms of Reference review.
- Approve the revised chairs and senior leader representation .
- Approve the proposal for a CIB decision/action log to replace minutes.
- Approve the proposed CIB agenda.
- Approve the proposed delivery groups reporting approach.
- Approve the development of a SEND local area data dashboard.

SEND CIB Governance Proposal

11th July 2023

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